AmeriHealth ADMINISTRATORS

| Today's date: |
|---|
| Date medication needed: |

# Prior Authorization Form – Botulinum Toxins

**ONLY COMPLETED REQUESTS WILL BE REVIEWED**

Select one: ☐ Botox® ☐ Dysport® ☐ Myobloc® ☐ Xeomin® Check one: ☐ New start ☐ Continued treatment
Number of units to be injected____________________

| **Patient information** (please print) | | | | |
|---|---|---|---|---|
| Patient name | | Patient ID # | | |
| Address | | City | State | Zip |
| Telephone | Date of birth | Weight | | |

| **Physician information** (please print) | | |
|---|---|---|
| Prescribing physician | | NPI |
| Office address | | |
| City | State | Zip |
| Office telephone # | Office contact | Fax # |

☐ No delivery requested; physician will use office supply. Authorization only.
☐ Delivery requested to the physician's office.

****A copy of the prescription must accompany the medication request for delivery.****

**1. Diagnosis for drug requested (must include ICD-10):**____________________

**2. Patient medical information**

***For hyperhidrosis only:***

a. Is the age of onset of hyperhidrosis younger than 25 years of age? ☐ Yes ☐ No
b. Is focal sweating bilateral and relatively symmetric? ☐ Yes ☐ No
c. Does the patient sweat during sleep? ☐ Yes ☐ No
d. Does the patient have a positive family history of severe primary focal hyperhidrosis? ☐ Yes ☐ No
e. Does the hyperhidrosis significantly impair the patient's participation in daily activities? ☐ Yes ☐ No
f. Does the patient have any underlying disease causing hyperhidrosis? ☐ Yes ☐ No
If yes please specify: ____________________
g. Which area will be treated? (e.g., palmar, plantar, axillary) ____________________
h. How many units will be injected into each area?____________________

***For chronic migraine or probable chronic migraine only:***

a. Has a neurologist established the diagnosis of chronic migraine headache? ☐ Yes ☐ No
b. Have the migraines occurred at least 15 days per month for at least 3 months? ☐ Yes ☐ No
c. Does the migraine last at least 4 hours per day? ☐ Yes ☐ No
d. Does the patient have either nausea or sensitivity to light and/or sound with the migraine? ☐ Yes ☐ No
e. How does the patient describe the pain associated with the migraine? (Select all that apply)
☐ Moderate-to-severe pain intensity
☐ Unilateral pain
☐ Pain aggravated by movement or that prohibits movement
☐ Throbbing pain
f. Has the patient failed to respond to a 4-week course of at least two agents from the different drug classes listed below? ☐ Yes ☐ No
If yes, list the drug(s) and the duration(s) below:
1. Tricyclic antidepressants; (list drug[s]/duration[s]) ____________________
2. Serotonin-norepinephrine reuptake inhibitors; (list drug[s]/duration[s]) ____________________
3. Selective serotonin reuptake inhibitors; (list drug[s]/duration[s]) ____________________
4. Anticonvulsants; (list drug[s]/duration[s]) ____________________
5. Beta-blockers; (list drug[s]/duration[s]) ____________________
6. Calcium channel blockers; (list drug[s]/duration[s]) ____________________
7. Other drug(s); (list drug[s]/duration[s]) ____________________

**3. Prescription information:**

Dosage____________Frequency____________ Refill x____________month(s)
Physician's signature ____________________

**Please fax this completed form to 215-784-0672.**

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